May 23, 2003

To Whom It May Concern:

The American Association of Nurse Assessment Coordinators (AANAC), based in Denver, Colorado, would like to submit for review comments on the Draft MDS 3.0. The Association represents 4700 nurse assessment coordinators/MDS coordinators and other members of the interdisciplinary team who work in free-standing and hospital based nursing homes across the United States and regularly complete the MDS 2.0.

General Comments:

Overall, the new MDS 3.0 incorporates many improvements compared to the current MDS 2.0. Clearly there has been a significant effort to clinically update the instrument, to reduce data entry, and to improve some of the key areas of the MDS.

One of our primary concerns with the proposed instrument is that the screening data collection instrument (MDS) changes seem to precede an analysis of the uses of the Resident Assessment Instrument (RAI). The MDS was originally presented as a primary screening clinical/data collection tool to trigger Resident Assessment Protocols (RAPs) for further resident assessment and planning. The RAPs are key to the clinical application of the MDS. We suggest that RAPs should be developed for the Quality of Life, Pain and Discharge Planning before data items for the MDS screening can be written.

When analysis is completed of the uses of data items on the MDS, we suggest that this information be included in the coding instructions so clinicians who complete the MDS can understand how the information should/will be used clinically, and to drive reimbursement and regulatory/consumer oversight. We believe that because this information is not currently clear to clinicians, this adversely affects the reliability of the instrument. For example, when asked to code the number of days the resident received injections in the last seven days, s/he often does not understand that this question is intended to measure acuity/stability of the resident condition (number of days of injections is a proxy for acuity/stability of condition) and it also examines costs associated with service for RN/LPN services versus CNA services. If the intent behind data collection is not obvious, the clinician is less likely to go to the Medication Administration Record and count the number of days of injections. Data collection for this item does not impact clinical practice so s/he has very little incentive to give priority to accurately coding this item. Going forward, we believe it would dramatically improve the reliability of each item on the MDS if the clinician were offered such explanation of the intended use of the item.

A related issue that we believe impacts the extent that clinicians accurately code an MDS is availability of supportive clinical research for the way items are designed. Often the rationale for an item is not immediately apparent to clinicians who are dedicating significant amounts of clinical time to completion of this form. For example, on the Draft MDS 3.0, 24 hours would not seem to be sufficient time to adequately assess pain. If there is research to support this, it would be helpful to provide that information. To increase their commitment to accurate coding, it is critical that clinicians understand that accurate completion of an item is firmly supported by clinical research and/or measurement research. With this information, they will be more confident that through accurate coding they will reap the benefits of knowing they have assessed accurately, will be reimbursed accurately, and that the quality indicators and quality measures will accurately reflect the care provided and the outcomes of such care.

In recent months we have become concerned that by using assessment items as the variables which drive quality measures, clinicians who identify conditions for which the resident may be at risk will be "punished" for accurately reporting their findings in completion of the MDS. For example, on an initial Admission assessment the clinician may identify that a resident is in pain and at the point of assessment/recognition of the problem, the pain has not been treated. Recognizing that untreated pain will adversely affect the quality measure for the facility, the clinician is faced with one of two choices. S/he can either treat the pain and delay completion of the MDS until s/he can report no pain, or s/he can report what s/he found on assessment and have such data be aggregated as a part of a quality measure and risk having it appear that there are residents with untreated pain. Most clinicians do not want to appear as though they or their facility are aware of pain and do not treat it when recognized. This leaves the clinicians in a double bind. This scenario is repeated time and time again when assessment items are used in aggregate and the public is led to believe that a conclusion can be drawn without further investigation using observation, record review, and interview to substantiate that such findings truly represent the quality of care provided by a facility. This why is it critical that the intent of each item on the MDS be clearly defined prior to its addition to the MDS 3.0. The multiple uses of the MDS leads to conflicting priorities, with the Nurse Coordinator in the middle.

For some of the lengthy sections, such as depression, quality of life, and pain, consider including key screening items on the MDS and trigger RAPs accordingly rather than including the entire assessment on the MDS.

We assume that the RUG items on the MDS cannot be changed because the grouper would be affected. If this is the case, we are concerned that clinicians will be faced with another major change in this form when RUG Refinement occurs, necessitating significant reeducation and retraining for the clinicians.

We are concerned that removing the "None of the above" responses from check lists will make computer validation that the MDS is complete impossible. Items such as E3, F2, I1, M5, M6, M7, etc. would benefit from "None of the above."

We assume there will be skip patterns for a number of items, however without the incorporation of the skip patterns into this draft it is difficult to evaluate the relative burden for staff who would likely take advantage of such time saving measures.

There are a number of instances on the MDS 3.0 where timeframes have been changed. Again, without rationale it is difficult to assess whether these changes are appropriate to the majority of residents in nursing facilities. We suggest that these changes be made with thoughtful consideration because this has been and continues to be an area of considerable misunderstanding for clinicians. We anticipate that retraining Coordinators would affect the reliability of the information for a considerable time into the future, were timeframes to be changed on the MDS 3.0.

It appears as though, at times, this tool is being used for clinical research. We feel this is not an appropriate use for the MDS as valuable time is taken from bedside nursing care when this occurs.

We recommend that Customary Routines be added back to the tool. We believe this is a most important section of the MDS from the standpoint of care planning for issues that are critically important to the resident.

This concludes our general remarks on development of the MDS 3.0 We have attached a separate word document with our item by item review of the instrument as well as the Excel file which you provided. If you have further questions related to these documents, please call.

We very much appreciated the opportunity to comment on this important tool which plays such a critical role in resident care, reimbursement and regulatory oversight and consumer information. If we can be of further assistance, do not hesitate to contact us.

Sincerely,
Diane Carter, RN, MSN
Executive Director

Rena Shephard, RN, BA, FACDONA
President